



## TEXAS DEPARTMENT OF INSURANCE

### Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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## MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

### GENERAL INFORMATION

**Requestor Name**

Christus SR Medical Center

**Respondent Name**

Liberty Insurance Corp

**MFDR Tracking Number**

M4-17-1033-01

**Carrier's Austin Representative**

Box Number 01

**MFDR Date Received**

December 13, 2016

### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "The following letter is a MEDICAL FEE DISPUTE appeal to TDI for Workers'

Compensation on behalf of LIBERTY MUTUAL. CHRISTUS Health received notification from Liberty Mutual questioning the medical efficacy of CPT Code 63047 and allograft amniotic membrane implant (0278) appropriateness for the above referenced hospital stay. Based on the medical record, CHRISTUS Health is of the opinion that the services were medically necessary for the treatment of the patient's condition."

**Amount in Dispute:** \$15,517.20

### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "Based on further review, this bill has been reimbursed at submitted DRG 517 CMS IPPS rate of \$10,986.63 @ 143% = \$15,710.88 which would include implant. The attached CMS IPPS pricing, prior bills submitted and EOB have been attached for review. It is noted separate implant reimbursement was not requested and a non-certified invoice inquiry was submitted on resubmission of the bill for amniofix membrane with vendor..."

**Response Submitted by:** Liberty Mutual

### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 13, 2016 to July 14, 2016	Inpatient Hospital Services	\$15,517.20	\$15,517.20

### FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

## **Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.404 sets out the acute care hospital fee guideline for inpatient services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - X079 – Please submit one or more of the following records which pertain to your bill; operative report, discharge summary, itemized bill, anesthesia records, medical report. For reconsideration please submit appeal with EOP and requested information
  - U301 – This item has been reviewed on a previously submitted bill; or is currently in process. Notification of decision has been previously provided or will be issued upon completion of our review

## **Issues**

1. Were the disputed services subject to a specific fee schedule set in a contract between the parties that complies with the requirements of Labor Code §413.011?
2. Which reimbursement calculation applies to the services in dispute?
3. What is the maximum allowable reimbursement for the services in dispute?
4. Is the requestor entitled to additional reimbursement for the disputed services?

## **Findings**

1. 28 Texas Administrative Code §134.404(e) states that: “Except as provided in subsection (h) of this section, regardless of billed amount, reimbursement shall be:
  - (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011; or
  - (2) if no contracted fee schedule exists that complies with Labor Code §413.011, the maximum allowable reimbursement (MAR) amount under subsection (f) of this section, including any applicable outlier payment amounts and reimbursement for implantables.”

No documentation was found to support the existence of a contractual agreement between the parties to this dispute; therefore the MAR can be established under §134.404(f).

2. §134.404(f) states that “The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.
  - (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
    - (A) 143 percent; unless
    - (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 108 percent.”

Review of medical bill finds the requestor billed with revenue code 278 however there is no documentation to support that the facility requested separate reimbursement for implantables; for that reason the MAR is calculated according to §134.404(f)(1)(A).

3. 134.404(f)(1)(A) establishes MAR by multiplying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors (including outliers) by 143%. Information regarding the calculation of Medicare IPPS payment rates may be found at <http://www.cms.gov>. Documentation found supports that the DRG assigned to the services in dispute is DRG, and that the services were provided at Christus SR Medical Center. Consideration of the DRG, location of the services, and bill-specific information results in a total Medicare facility specific allowable amount of 11,035.36. This amount multiplied by 143% results in a MAR of \$15,780.56.

4. The total allowable reimbursement for the services in dispute is \$15,780.56. The amount previously paid by the insurance carrier is \$0.00. The requestor is seeking additional reimbursement in the amount of \$15,517.20. This amount is recommended. .

### **Conclusion**

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$15,517.20.

### ***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$15,517.20 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

### **Authorized Signature**

_____	_____	1/27/2017
Signature	Medical Fee Dispute Resolution Officer	Date

### ***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**